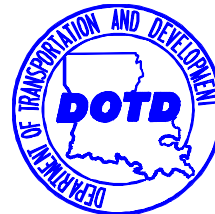




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**CERTIFICATION OF PHYSICIAN OR PRACTITIONER  
(Family and Medical Leave Act of 1993)**

The information provided should only relate to the condition for which FMLA is being requested.

1. Employee's Name \_\_\_\_\_
2. Patient's Name (if other than employee) \_\_\_\_\_
3. A "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition in one of the following categories: (Please check applicable category).  
\*The attached sheet describes what is meant by a serious health condition under the Family and Medical Leave Act.  

_____ hospital care	_____ absence plus treatment	_____ pregnancy
_____ chronic conditions requiring treatments	_____ permanent/long term conditions requiring supervision	_____ multiple treatments (non-chronic conditions)
_____ other: explain: _____		
4. If the patient's condition qualified under one of the above categories, describe medical facts which support your certification and explain how your findings meet the criteria of that category?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
5. Give approximate date on which the condition commenced, probable duration of the condition, and include probable duration of patient's present incapacity if different. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
6. Where additional treatments are required for the condition, state probable number of treatments. ("Treatments" for purposes of FMLA, includes examinations to determine if a serious health condition exists and evaluations of the condition). \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. If any treatments are to be administered by another health care provider, state the nature of the treatments:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
8. If a patient must undergo a regimen of continuing treatment under your supervision, give a general overview of the regimen (e.g. prescription drugs, physical therapy requiring special equipment).  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IF THIS CERTIFICATE RELATES TO THE CARE OF THE EMPLOYEE'S SERIOUSLY ILL FAMILY MEMBER, SKIP ITEMS 9, 10, 11, AND 12, AND PROCEED TO ITEMS 13 THROUGH 15.**

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A DRUG FREE WORKPLACE

ATTACHMENT 1

9. Does the employee need to be off work intermittently or work less than a full work schedule due to his/her condition? \_\_\_\_\_ If yes, give probable duration. \_\_\_\_\_

10. Is the condition a chronic condition or pregnancy and if so, is the patient incapacitated or will the patient become incapacitated? ("Incapacity" for purposes of FMLA, is defined to mean inability to work, attend school, or perform other regular daily activities due to the serious health condition, treatment thereof, or recovery there from).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If yes, give the approximate duration and frequency of period of incapacity. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

11. Will it be necessary for the employee to be absent from work for treatment? \_\_\_\_\_

12. When an employee requests medical leave due to absence from work for his/her own condition (including absences due to pregnancy or a chronic condition), is the employee able to perform the essential functions of his/her position? (Answer after reviewing statement from employer of essential functions of employee's position, or if not provided, after discussing with employee).

\_\_\_\_\_  
\_\_\_\_\_

If yes, list the essential functions of the job that the employee is able to perform. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

If no, list the essential functions of the job that the employee is unable to perform. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**TO BE COMPLETED BY THE EMPLOYEE REQUESTING FAMILY LEAVE TO CARE FOR A FAMILY MEMBER**

13. When an employee requests leave to care for a family member with a serious health condition, does (or will) the patient require assistance for basic medical or personal needs or safety, or for transportation? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

14. If the employee's presence is not required as stated in Item 13, would his/her presence provide psychological comfort beneficial to the patient or assist in the patient's recovery? \_\_\_\_\_

\_\_\_\_\_

Estimate the period of time care is needed or the employee's presence would be beneficial to the patient. \_\_\_\_\_

\_\_\_\_\_

15. When family leave is needed to care for a family member with a serious health condition, state the care you will provide, estimate the time period which this care will be provided, and include a schedule if leave is to be taken intermittently or on a reduced leave schedule.

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Health Care Provider

\_\_\_\_\_  
Date

\_\_\_\_\_  
Type of Practice

\_\_\_\_\_  
Area Code and Telephone Number